PRIOR APPROVAL REQUEST
BACTROBAN
(Mucopirocin 2%)

NDC #_____Quantity Prescribed _____

Patient's Name _____Patient's DOB_____

Patient's Nine Digit Public Aid # _____

Patient in LTC Facility - Facility Name & Phone #_____

Treatment Nurse's Name _____

Physician's Name _____Office Phone #_____

Physician's DEA or State License # _____

Physician's Signature _____ Date _____

Patient Has: [ ] Cellulitis [ ] Superficial Skin Infection B Specify (e.g. Impetigo, Infected Abrasion) _____[ ] Other-Specify (e.g. Infected Burn, Infected G-Tube Site, Infected _____)

Duration of Lesion _____ Days _____ Weeks _____ Months

Size of Lesion (Cm) _____Length _____ Width _____ Depth

Wound Culture Results (If Within One Month) _____

Previous Treatment With Dates _____
_____

Expected Duration of Bactroban Treatment _____

Pharmacy_____Provider No_____
Phone_____

Requests With Incomplete Information Will Not Be Approved.

Bactroban Prescribed For Non-FDA Approved Indications Requires U.S. Published, Peer Reviewed Literature Which Provides Data Which Supports Such Use.

Please Fax to: 217-524-7264 ATTN: Medical Committee

Revised 03/17-03